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CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: Please complete Section I before giving this form to your employee. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Alabama Department of Finance, Elizabeth Allen, Personnel Director

Employee's essential job functions: Ability to demonstrate functional competence in performance of tasks as indicated in responsibilities and results, and satisfactory attendance.

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

Job title: _____ Regular work schedule: _____

Work telephone number: _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. **Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage**. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name: _____

Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
_____ No _____ Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition?
_____ No _____Yes.

Was medication, other than over-the-counter medication, prescribed? ____ No _____Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? _____ No _____Yes.

If so, state the nature of such treatments and expected duration of treatment: _____

_____

2. Is the medical condition pregnancy? _____No _____Yes.
If so, expected delivery date: _____.

3. Use the information provided by the employer in Section I to answer this question. If the employer failed to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition:

   _____ No _____Yes.

   If so, identify the job functions the employee is unable to perform: _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, **diagnosis**, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?
   _____ No _____Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

   _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?
   _____ No _____Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   _____ No _____Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____hour(s) per day; _____days per week from _____through_____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____ No _____Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups? _____ No _____Yes. If so, explain: _____

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____times per _____ week(s) _____ month(s)

   Duration: _____ hours or _____day(s) per episode

ADDITIONAL INFORMATION. IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**